KANSAS STATE BOARD OF PHARMACY
LANDON STATE OFFICE BUILDING
900 SW JACKSON, ROOM 560
TOPEKA, KS 66612
(785) 296-4056
FAX (785) 296-8420

FOR OFFICE USE ONLY

REG NUMBER_____

DATE_____

FEE: $300.00

APPLICATION FOR DISTRIBUTE PRESCRIPTION DRUGS, DEVICES AND/OR CONTROLLED SUBSTANCES

Application for registration to distribute prescription drugs and/or controlled substances at wholesale in the State of Kansas is hereby made.

_____

Applicant's name (legal entity which owns the drug distribution business)

_____

Other trade or business names used by applicant in the distribution of prescription drugs and/or controlled substances:

_____

Business Street Address:

_____(_____)_____(_____)_____

City State Zip Telephone Number Fax Number

Ownership form: _____Individual Person(s) _____Partnership _____Corporation _____Sole proprietorship

If **individual person(s)**, provide the name of the owner(s), and name of operator if different from owner(s)
If a **partnership**, provide the name of each partner and the name of the partnership.
If a **corporation**, provide the name and title of each corporate officer and the director, and the state where incorporated.
If a **sole proprietorship**, provide the full name of the sole proprietor and the name of the business entity.

_____

Name of person submitting application:

_____

Relationship to applicant:

_____

Name of facility where prescription and /or controlled substances will be stored, handled or distributed at wholesale:

_____

Address

_____(_____)_____(_____)_____

City State Zip Telephone Number Fax Number

_____

Contact Person/Authorized Agent

_____

Name and address for renewals, newsletters and registration to be mailed to:

_____

City State Zip

This application is being made to cover the following types of drugs (Check all that apply)
_____Prescription Drugs(noncontrolled) and Devices _____Nonprescription Drugs _____Schedule II/Narcotic
_____Schedule II/nonnarcotic _____Schedule III/narcotic _____Schedule III/nonnarcotic _____Schedule IV _____Schedule V
_____Medical Gas Repacker (Please enclose a copy of your DEA Registration) _____Durable Medical Equipment _____Transfilled Oxygen

This application is being made to cover the following reason(s) (Check all that apply)
_____Original registration _____Change of location _____Change of ownership _____Change of business name

Effective date_____
In which other state(s) is your facility licesnsed?_____
Is the distributor registered with the appropriate state regulatory agency in the state of residence? _____Yes _____No
Please attach a copy of the most recent inspection report conducted by the state's licensing agency
Is applicant registered by DEA to dispense controlled substances? _____Yes _____No
If yes, please enclose a copy of your DEA certificate.

In relation to the following questions, "applicant" includes the legal entity, which owns the distribution business as well as each individual owner, partner, corporate officer and director.

1. Has the applicant been convicted under any federal, state or local laws relating to drug samples, wholesale or retail drug distribution or distribution of controlled substances? _____Yes _____No
2. Has applicant been convicted of any felony under federal or state laws ? _____Yes _____No
3. Has any license or registration, currently or previously held by applicant been surrendered, suspended or revoked by federal, state or local government for the manufacture or distribution of any drugs, including controlled substances? _____Yes _____No
4. Has applicant ever furnished false or fraudulent material in any application made in connection with drug manufacturing or Distribution? _____Yes _____No

If any of the above questions are answered "yes," provide a detailed explanation on a separate page.

5. Has applicant complied with registration requirements under previously granted registration, if any? _____Yes _____No
6. Has applicant complied with requirements to maintain or make available to the Board or to federal, state or local law enforcement officials those records required by the Federal Food, Drug and Cosmetic Act? _____Yes _____No
7. Has each person employed in any prescription drug wholesale distribution activity had education, training, or experience sufficient for that person to perform the assigned functions in such manner as to provide assurance that the drug product quality, safety and security will at all times be maintained as required by law? _____Yes _____No

If any of the above questions are answered "no," provide a detailed explanation on a separate page.

8. What is applicant's past experience in the manufacture or distribution of prescription drugs, including controlled substances? Provide a detailed explanation.

OWNER/CORPORATE PORTION

I, _____, solemnly swear (or affirm) that the statements and representations made in the foregoing application and all attachments are true and correct to the best of my knowledge and understands that this registration, if issued, will expire annually on the 30th day of June and such registration will be cancelled if not renewed annually by the 31st day of July.

_____

SIGNATURE OF OWNER/OFFICER

Signed and sworn to (or affirmed) before me on _____ day of _____, 20_____.

(Seal) My commission expires _____

_____

SIGNATURE OF NOTARY PUBLIC

CONTACT PERSON/AUTHORIZED REPRESENTATIVE PORTION

I, _____, solemnly swear (or affirm) that the statements and representations made in the foregoing application and all attachments are true and correct to the best of my knowledge and understands that this registration, if issued, will expire annually on the 30th day of June and such registration will be cancelled if not renewed annually by the 31st day of July.

_____

SIGNATURE OF CONTACT PERSON/AUTHORIZED REP.

Signed and sworn to (or affirmed) before me on _____ day of _____, 20_____.

(Seal) My commission expires _____

_____

SIGNATURE OF NOTARY PUBLIC

BOTH THE OWNER/CORPORATE **AND** CONTACT PERSON/AUTHORIZED REPRESENTATIVE PORTIONS MUST BE SIGNED AND NOTARIZED.